

Dr. Barb Boeding and Dr. Kara Speltz Family Dentistry

321 East Main Street, New Hampton, Iowa 50659 (641)394-3016

Patient Information

Patient's Name:

_____ Last Name _____ First Name _____ M.I.

Preferred Name: _____

Single Married Divorced Widowed Child

Social Security #: _____

Birth Date: _____ Sex: _____ Age: _____

Address: _____

City _____ State: _____ Zip: _____

Home #: _____

Work #: _____ Cell #: _____

Patient's Employer: _____

Spouse's Name: _____

Spouse's Employer: _____

If Patient is a Minor, Complete Below

Mother's Name: _____ Home #: _____

Work #: _____ Cell #: _____

Father's Name: _____ Home #: _____

Work #: _____ Cell #: _____

Dental Insurance

Name of Insured: _____

Insured's Birth Date: _____

Insured's Social Security #: _____

Insured's Employer: _____

Insured's Insurance Company: _____

Group #: _____

Secondary Dental Insurance

Name of Insured: _____

Insured's Birth Date: _____

Insured's Social Security #: _____

Insured's Employer: _____

Insured's Insurance Company: _____

Group #: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered, I agree to pay any co-payment amount due at the time of service. I fully understand I am solely responsible for any balance not paid by my insurance company.

Signature: _____

Billing Information

In order to keep our billing costs and fees lower, payment is expected at the time of service unless prior arrangements have been made. Any accounts 60 days or more will receive an 18% annual interest fee applied to your account.

Methods of payment offered are listed below. Please check the option which you prefer.

Cash Personal Check Credit Card Other

Emergency Contact Information

Contact Person's Name: _____

Phone #: _____

Account Information

Person responsible for account

Name: _____

Relationship to Patient: _____

Birth Date: _____

Social Security #: _____

Address: _____

City _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Employer: _____

Spouse's Name: _____

Spouse's Employer: _____

Who may we thank for referring you to our office?

Dr. Barb Boeding and Dr. Kara Speltz Family Dentistry

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Dental Information

Reason for today's visit: _____

Are you in pain? Yes No If yes, how long have you been in pain? _____

Please indicate any of the following problems:

- | | | |
|---|---|--|
| <input type="checkbox"/> discomfort, clicking or popping in jaw | <input type="checkbox"/> lost/broken filling(s) | <input type="checkbox"/> stained teeth |
| <input type="checkbox"/> red, swollen or bleeding gums | <input type="checkbox"/> teeth grinding | <input type="checkbox"/> locking jaw |
| <input type="checkbox"/> sensitive tooth, teeth or gums | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> bad breath |
| <input type="checkbox"/> blisters/sores in or around mouth | <input type="checkbox"/> broken/chipped tooth | |
| <input type="checkbox"/> other: _____ | | |

Do you require pre-medication? Yes No Don't know

Previous Dentist's Name: _____

Last Dental Exam: _____ Last Dental X-Rays: _____

Do you have any concerns about dental treatment? _____

Are you interested in whitening your teeth? Yes No Do you use tobacco? Yes No

Medical History

Indicate which of the following you have had, or have at the present time. Circle **Yes** or **No** for each item.

- | | | |
|--|--------------------------|-----------------------------------|
| Yes No Heart (Surgery, Disease, Attack) | Yes No Ulcers | Yes No Hepatitis |
| Yes No Chest Pain | Yes No Diabetes | Yes No Venereal Disease |
| Yes No Congenital Heart Disease | Yes No Thyroid Problems | Yes No A.I.D.S. |
| Yes No Heart Murmur | Yes No Glaucoma | Yes No HIV Positive |
| Yes No High Blood Pressure | Yes No Contact Lenses | Yes No Blood Transfusion |
| Yes No Mitral Valve Prolapse | Yes No Emphysema | Yes No Alcohol/Drug Abuse |
| Yes No Artificial Heart Valve | Yes No Tuberculosis | Yes No Liver Disease |
| Yes No Heart Pacemaker | Yes No Asthma | Yes No Neurological Disorder |
| Yes No Rheumatic Fever | Yes No Latex Sensitivity | Yes No Epilepsy/Seizures/Fainting |
| Yes No Arthritis/Rheumatism | Yes No Sinus Trouble | Yes No Nervous/Anxious |
| Yes No Stroke | Yes No Tumors | Yes No Allergies or Hives |
| Yes No Radiation Therapy | Yes No Chemotherapy | Yes No Kidney Trouble |
| Yes No Artificial Joints (hip, knee, etc.) | Yes No Psychiatric Care | Yes No Taking Blood Thinners |

Please list any other medical condition(s) you have had, or have at the present time: _____

Please list the name and dosage for any current medications, drugs, or pills you are taking: _____

Are you aware of having an allergic reaction to any medications or substances? Yes No If yes, please explain: _____

Medical Doctor's Name: _____ Pharmacy: _____

Women: Are you pregnant? Yes No ___ months Are you nursing? Yes No Taking birth control pills? Yes No

Authorization and Release

I authorize the doctor, or designated staff, to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medications and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform Dr. Boeding and Dr. Speltz Family Dentistry's office of any changes to the information I have provided.

Signature: _____ Patient Parent or Guardian Spouse

Date: _____